

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038979

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

1215

STATE FILE NUMBER

FILED OCT 21 1963

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF  
C. Smith, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Joseph</b>		Length of stay in 1b <b>unknown</b>	
c. FULL NAME OF (If NOT in hospital, give location) <b>State Hospital No. 2</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>2602 Mitchell Avenue</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Theodore Albert Conroy</b>		4. DATE OF DEATH Month <b>October</b> Day <b>16</b> , Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-22-1887</b>
9. AGE (last birthday) <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>boiler maker</b>	
11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Thomas H. Conroy</b>		13b. MOTHER'S MAIDEN NAME <b>Katherine Tertling</b>	
14. NAME OF HUSBAND OR WIFE <b>Bertha B. Conroy</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Records of State Hospital No. 2</b>		17. INFORMANT <b>Records of State Hospital No. 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> DUE TO (b) <b>General arteriosclerosis</b> DUE TO (c) <b>over 3 yrs.</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <b>St. Joseph, Mo.</b>		COUNTY <b>Buchanan</b> STATE <b>Missouri</b>	
21. I attended the deceased from <b>Sept. 25, 1962</b> to <b>Oct. 16, 1963</b> and last saw him alive on <b>10-14-63</b> Death occurred at <b>9:15</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <i>C. Smith</i>	
22b. ADDRESS <b>State Hospital No. 2</b>		22c. DATE SIGNED <b>10-16-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 19, 1963</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>	
24. FUNERAL DIRECTOR <b>H. O. Sidenfaden &amp; Son</b>		25. DATE RECD. BY LOCAL REG. <b>Oct. 17, 1963</b>	
26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

Permit issued 10-17-63

FILE  
FIVE  
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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert H. Geph

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.